

EXHIBIT A

Form 5500	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2020 This Form is Open to Public Inspection
Department of the Treasury Internal Revenue Service		
Department of Labor Employee Benefits Security Administration		
Pension Benefit Guaranty Corporation		

Part I Annual Report Identification Information		
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>		
A This return/report is for:	<input type="checkbox"/> a multiemployer plan	<input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a DFE (specify) _____
B This return/report is:	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>	
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension
	<input type="checkbox"/> special extension (enter description)	<input type="checkbox"/> the DFVC program

Part II Basic Plan Information —enter all requested information	
1a Name of plan <u>CIGNA MEDICAL PLAN</u>	1b Three-digit plan number (PN) ► <u>520</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>CIGNA HOLDING COMPANY</u> <u>1601 CHESTNUT STREET, TL05T</u> <u>PHLADELPHIA, PA 19192</u>	2b Employer Identification Number (EIN) <u>06-1059331</u>
	2c Plan Sponsor's telephone number <u>215-761-2320</u>
	2d Business code (see instructions) <u>524290</u>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	10/14/2021	ALICIA VASLOW
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	Date	Enter name of individual signing as plan administrator
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2020)
v. 200204

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor		3b Administrator's EIN 82-2902313
CIGNA HEALTH & WALARE PLAN COMMITTEE (JILL VASLOW) 1601 CHESTNUT STREET, LT05T PHILADELPHIA, PA 19192		3c Administrator's telephone number 215-761-2320
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:		4b EIN
a Sponsor's name		4d PN
c Plan Name		
5 Total number of participants at the beginning of the plan year		5 59900
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year.....		6a(1) 59900
a(2) Total number of active participants at the end of the plan year		6a(2) 55778
b Retired or separated participants receiving benefits.....		6b 0
c Other retired or separated participants entitled to future benefits		6c 0
d Subtotal. Add lines 6a(2), 6b, and 6c		6d 55778
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e
f Total. Add lines 6d and 6e		6f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:		
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4E		
9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance		(1) <input type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts		(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust		(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor		(4) <input type="checkbox"/> General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)		
a Pension Schedules		b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input type="checkbox"/> A (Insurance Information)
		(4) <input type="checkbox"/> C (Service Provider Information)
		(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)
		(6) <input type="checkbox"/> G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____